Appendix C: Analysis of Quality Assurance Plans - HMOs

Methodology

At the commencement of the study, all quality assurance plans from HMOs licensed in the Commonwealth on file with the Bureau of Insurance were copied and sent to the Department of Health Evaluation Sciences at the University of Virginia. Researchers answered the questions contained in the analytical frameworks based on these documents. Interviews with the person or people deemed most responsible for these plans were arranged to go over the lists of questions for clarification. After three interviews with HMO representatives, it was determined that the documents received at DHES from the Bureau of Insurance were not the most current quality assurance plans. In order to rectify this problem, the study methodology was changed slightly, allowing the HMOs to present their current plans. A tracking chart listing the HMOs and the status of their submissions follows the analysis of the grievance plans in Appendix E.

Based on several descriptive factors, a representative sample of HMOs licensed in Virginia was chosen for inclusion in the study. These factors included age of the plan, geographic region of service area, status of NCQA accreditation, number of total members and number of Virginia members, state of domicile, and tax-status. A total of seventeen (17) HMOs were chosen. In some cases, more than one plan from a particular company was chosen in order to make comparisons within companies. Contact information for each HMO was obtained from the Virginia HMO Association.

A research assistant initiated contact with the people deemed most responsible for QA plans at each plan. In some cases, the research assistant was referred to other employees of the plan. Once the correct person was reached, the research assistant explained the purpose of the study and outlined the requirements of participation. When consent was obtained, the research assistant faxed the lists of questions relating to the quality assurance plans. Each plan was instructed to complete the questions with relevant citations noted and to send current QA plans to DHES. They were requested to complete these tasks within 5 working days, and report back if they could not meet this deadline. Follow-up phone calls were utilized as reminders to those plans that did not respond within this time frame.

Questions for the study were provided by the Virginia Department of Health in consultation with the HB 2785 Study Group. All questions were sent to all potential participants in the study.

The following HMOs were contacted regarding their QA plans: Aetna, Cigna-MidAtlantic, Cigna-Virginia, HealthKeepers, HMO Virginia, John Deere, MD-IPA (part of MAMSI), NYLCare, Optima, Optimum Choice (part of MAMSI), Partners, Prudential-MidAtlantic, Prudential-Richmond (PruCare), QualChoice, Sentara, US Healthcare (now part of Aetna), and Virginia Chartered. Virginia Chartered was dropped from the study because no

person able to respond to the questions could be reached within the study time frame. Responses were received from John Deere, MD-IPA, NYLCare, Optimum Choice, Partners, Prudential-MidAtlantic, Prudential-Richmond (PruCare), NYLCare, HealthKeepers, HMO Virginia, Aetna/United Healthcare, and QualChoice.

Once the documentation and completed questionnaires were received at DHES, the researchers examined the answers and citations for completeness, accuracy, and clarity. Any questions were referred back to the individual plans. In addition, DHES interviewed appropriate personnel in order to supplement the information provided by the answers to the questions. Quality assurance plans were compared to NCQA standards and to the seven components of the definition of quality determined by the August 1996 round table (see Chapter 2).

Analysis

Quality Assurance Plans

Twelve HMOs returned the completed questionnaire concerning their quality assurance plans. One HMO did not return the completed questionnaire but did provide documentation of their procedures, so analysis was done on the information available. One company did not submit a current quality assurance plan with their responses, so their answers could not be verified. The response rate, including the plan that only provided their QA plan, was 81%, and it can be reasonably assumed that these thirteen HMOs may be deemed a representative sample of all HMOs in the Commonwealth. Three companies, Aetna (which owns United Healthcare), Trigon (HMO Virginia and HealthKeepers), and MAMSI (MD-IPA and Optimum Choice), use the same quality assurance plans for all their HMO products. Therefore, analysis was done on the quality assurance plans submitted by each company rather than each plan, resulting in a total of nine QA plans. Certain patterns in these QA plans emerged that merit consideration. Each question in the analytical framework has been answered using responses from the companies, followed by comments from the researchers. In some cases, the answers to the questions were not explicitly stated in the quality assurance plans for each plan. This has been noted where appropriate.

ANALYTICAL FRAMEWORK FOR EXAMINATION OF HMO QUALITY ASSURANCE PLANS

1. Prevention

a. Identify the QA plan's goals and objectives that address preventive care. Name, if applicable, specific HEDIS measures that will be undertaken (e.g., cholesterol screening, diabetic retinopathy exam, mammography recommendation, etc.) If HEDIS measures are planned, describe what efforts the plan is making to ensure valid and reliable encounter data.

Seven companies reported that they will be collecting all HEDIS measures utilizing HEDIS methodology as evidenced in their QA work plan. These companies had specific care objectives for preventive care in diabetes, asthma, mammography, and immunization among others. Specific goals and objectives were outlined in the QA plans. One of these seven companies specifically mentioned their plans to have an outside contractor examine their data collection and reporting exercises for accuracy; another of the seven described a list of HEDIS measures and targets they will be examining along with their methodology. One company did not report using any HEDIS measurements, but did outline many preventive studies that are related to HEDIS measures. Another company also doesn't use HEDIS measures, but did state they conduct annual reviews on at least four preventive services.

Comments: Many companies are using HEDIS recommendations and measures to study preventive care. This information was found in the QA plans of all companies. NCQA requires these activities for accreditation.

b. Are prevention guidelines developed by the HMO or does the plan make reference to national practice guidelines? How?

One company stated that they develop guidelines for both adult and pediatric populations based on and adapted from the American Academy of Family Physicians (AAFP), the Advisory Committee on Immunization Practices (ACIP), and the American Academy of Pediatrics (AAP). Annually, preventive health guidelines and practice guidelines are reviewed by peer review committees, medical directors, and quality improvement committees. This company also provided specific quality of care measures for their plans over a three-year period and compared them to Healthy People 2000 criteria.

Six companies made reference to internal development of prevention guidelines by using accepted practice standards from various professional associations and the Agency for Health Care Policy and Research. One of these companies documents the source of recommendations at the end of each internally developed guideline; these sources include Healthy People 2000, American College of Physicians (ACP), AAFP, AAP, American College of Obstetrics and Gynecology (ACOG), and the US Preventive Services Task Force. One of these companies has adopted the US Preventive Services Task Force Guidelines as its standard for

preventive services, and one company used USPSTF guidelines to help craft internally developed company guidelines. One company used preventive standards published by Health Care Operations. Two companies did not elaborate.

Only one of the nine companies mentioned which national organizations were consulted within their QA plans, but the provisions for guideline development were available in the other plans.

Comments: Only one company reported that they use guidelines developed by an outside agency. Most plans uses national standards and modify them for use in their particular plans. The methods used to reach these guidelines are often not clear, but the process does allow for much feedback from many facets of the company.

c. Are there indications in the plan that guidelines for preventive care are shared with providers or that provider input was solicited?

One company reviews their guidelines for preventive care annually using a committee of medical directors and peer reviewers. Guidelines are forwarded to all members, including providers, annually. For one company, guidelines are forwarded to all plan providers for comment within a 45 day period. Another company forwards their draft guidelines to a peer review committee and the plan's medical directors for comment; final guidelines are distributed to all members and practitioners annually, but feedback is not solicited at this stage. One company distributes a reference guide to all providers and has provider participation on guidelines committees. One company has their guidelines reviewed annually by a subcommittee of providers. Two other companies utilize appropriate providers during guideline development and review all guidelines annually. One company utilizes a physician QA committee that aids in all aspects of guideline development and review. One company reported that they do not currently share guidelines with providers, but they have implemented distribution for 1997 and demonstrate provider input through their preventive services committee. This information was found in the QA plans of two companies, and it was absent in the QA plans for seven companies.

Comments: Provider input into development is important if a plan wants their providers to embrace their guidelines. These companies seem to value and seek provider input.

2. Complaint Resolution

a. What provisions does the plan make for aggregation and analysis of complaints and grievances?

Two companies aggregate and analyze their data on a quarterly and yearly basis, and continue to track each type of complaint over multiple years. This was stated in the QA plan of both companies. One company separates complaints and grievances from denials and appeals, with the former being analyzed every six months and the latter being analyzed at least annually; this information was in their QA plan.

One company sends monthly reports to its regional offices as well as providing quarterly and annual reports; this company uses the information during the recertification process for each of their offices. One company summarizes their data at least annually and aggregate data by provider. In addition, all written grievances are forwarded to the provider involved (with the permission of the member). One company logs all complaints and analyzes them to identify areas for improvement; appeals for denial of care are analyzed separately.

One company referenced a Quality of Care Identification and Tracking Process, but details about this process were not provided. Another company mentioned a Service Enhancement Tracking System, but again, details were not provided.

One company did not answer this question, but their QA plan shows many provisions for routine aggregation and analysis of complaints and grievances.

Comments: Information about complaints and grievances is gathered on a regular basis, as is required by NCQA and parts of the Code of Virginia. Frequency of reporting does not always appear in the QA plans, but mechanisms for collecting the data are documented.

b. What is the physician's office told with respect to appealing a denial for a service? Are they given the name and number of the medical director? Is there a physician/provider helpline?

One company does not deny payment for treatment ordered by a patient's PCP. However, if there is a denial of coverage, the physician is contacted with a name and number to call. Two companies notify physicians about denial of services either verbally or in writing, depending on the type of denial. Information about how to appeal is available either verbally at the time of denial or in the letter of denial.

One company provides both verbal and written responses to physicians for all denials of service. One company sends copies of all letters of denials directly to the physician's office. This letter mentions that an appeal process is available, and this information can also be obtained by phone.

Two companies have a special process in place to inform providers about denials. One company submitted a separate policy that described the process. One company made reference to their Medical Appeals policy.

The name and number of the medical director are available upon request at seven companies; one company includes the name of the deciding medical director in the letter of denial. This information could not be determined for the company that did not submit survey answers.

One company does not have a specific provider helpline, but there is a department that focuses on their needs. Four companies do have a specific helpline dedicated to providers, while two utilize their regular customer service department to help providers. This information could not be determined for the company that did not submit survey answers, nor was it found in the QA plan for the company that did not answer this question.

Comments: This information should be contained in written notifications of denial and communicated verbally when a provider calls the plan. This information is often found in provider handbooks.

c. What provisions does the plan make for systematic follow-up and corrective action on identified problems?

Eight companies have a formal process for systematic follow-up and corrective action. Complaints are aggregated and analyzed for patterns, and the QA plan makes provisions for examining them further. Complaints regarding providers are handled by a very detailed process described in the QA plan of four companies. One company documents problems in their QA committee meeting minutes and reviews provider problems at the time of recredentialing, but this was not documented in their QA plan.

One company reported that they have appropriate departments work together to resolve issues, but no formal system was described in their QA plan.

Comments: Most plans have a formal system for follow-up and corrective action about identified problems, but details were not (perhaps could not) be given in the QA plans.

3. Access and Availability

a. What activities does the plan describe for monitoring access and availability?

One company has a special department that monitors the ratio of members to primary care physicians (PCP). Provisions appear in the QA plan to monitor this ratio and remedy problems, but there is no indication of frequency of reviews. Two companies have several objectives for monitoring access in the QA plan, but do not give specific targets. Two companies assigned a person to monitor these issues in their work plan, but did not state specific targets. One of these two companies did, however, provide an extensive chart in their written responses to the study question. Three companies described in detail their processes: access surveys, consumer surveys, and provider surveys. One company did not specifically mention access in their QA plan, but it does track all quality improvement measures on a quarterly basis.

Comments: Most companies are monitoring access and availability.

b. What are the standards for appointment availability for routine, urgent, emergency care?

Standards for appointment availability for routine care ranged from 3 days to 12 weeks; for urgent care from 24 to 48 hours; and for emergency care from immediately to within 24 hours.

One company set the appointment standards within 90 days for routine care and within 24 hours for urgent/emergency care. These standards are not indicated in the QA plan. One company set the appointment standards at within 5 days for routine care, within 24 to 48

hours for urgent care, and immediately for emergency care, but these standards did not appear in the QA plan. One company sets their standards at 2 weeks for routine care, 48 hours for urgent care, and immediately or less than 24 hours for emergency care. This was outlined in detail in a chart in their written answers, but did not appear in their QA plan. One company outlined these standards in detail in their QA plan: 4 to 8 weeks for routine care, 24 to 48 hours for urgent care, and immediately for emergency care. Two companies had the following standards: 2 weeks for routine care, 24 hours for urgent care, and immediately for emergency care. Both companies reported these standards in their QA plan. One company had a standard of 12-16 days for routine care and the next working day for urgent care, but this was not found in the QA plan. One company has a standard of within 3 days for a non-urgent appointment and within the same day for urgent visits; this information could not be verified because the company did not submit a current QA plan. One company used the standards of 12 weeks for routine care, 24 hours for urgent care, and immediate access for emergency care.

Comments: Information concerning access to providers is mentioned in all QA plans, but specific information is not always detailed. The definition of routine care was not always constant: some companies define routine care as non-symptomatic, non-emergency care (such as physicals), while others define it as symptomatic, non-urgent care. This can probably explain the wide variation in standards.

c. What are the standards regarding PCP access? (e.g., ratio of PCPs to members; travel times; closed panels) Does the plan offer any incentives to PCPs to keep their panels open to new members? Are there any other incentives to improve access?

One company has a ratio set at 1500 patients per PCP and 500 patients per licensed physician extender. They also have standards for PCP access of 2 PCPs within 10 miles; one physician within 30 miles; and one hospital within 30 miles. One company had a ratio of 97 patients per PCP, but stated their goal is 250 patients per PCP. This plan also maintains a standard of one PCP within 30 miles. One company divides their geographic distributions into urban, suburban, and rural with different access goals for each. They do have a set ratio of 1 PCP per 250 members for each geographic region. In addition, they have goals for number of PCPs with open panels (90%) and choice of PCPs (members have a choice of 3 PCPs in their region). Two companies reported that 85% of members must have a choice of at least two PCPs within 8 miles of their residence in urban areas, fifteen miles in non-urban areas, and thirty miles in rural areas; provider to patient ratios were not given. One company noted that their providers or designees should be available 24 hours a day/seven days a week for emergency care and that patients with scheduled appointments should not wait more than 30 minutes, but did not give specific patient ratios. One company requires that their PCPs accept 250 members into their practice, and stated that all members must be able to reach a PCP within 20 minutes driving and a hospital within 30 minutes driving. One company has an access standard of at least one PCP within 30 minutes for both urban and rural members. One company did not give specific standards, but did note that access has not been a problem according to member surveys.

One company does not offer incentives to PCPs to keep their panels open, but closure is not allowed for panels with less than 250 members. One company pays additional fees to PCPs if the practice is open to new members; if access issues arise, the provider may be subject to reduced reimbursement or it may be considered during the recredentialing process. One company uses an incentive program to keep panels open. One company offers incentives to PCPs who have open panels and extended office hours, and also continues to recruit PCPs in geographic areas that do not meet their standards for access. One company gives special payments to offices open to new members that increase the base capitation rate. Four companies do not offer incentives, but one of these companies does give PCPs quarterly bonuses for having an open panel and extended office hours.

Comments: Some standards are documented in the QA plan for three companies. Five companies did not mention these standards in their plan at all, and one company described activities to improve access in their QA work plan but did not give specific targets or current policies. Information could not be verified for the plan that did not provide their QA plan. Most companies use GEOAccess to track PCP coverage. It should be noted that some companies might have reported minimum PCP to patient ratios, which are business decisions, rather than maximum ratios, which could be quality indicators.

d. Is the formulary binding or advisory?

Five companies state that their formulary is advisory. The formulary is binding in two companies. One company did not answer this question, and it was not documented in their QA plan. The answer to this question was not documented in the QA plan for the company that did not return the study questions.

e. Which pre-certification requests CANNOT be done on the phone, but require medical record review?

One company reports that no pre-certification requests can be done on the phone. One company stated that all pre-certifications can be done on the phone except those that require x-rays or dental and cosmetic procedures. Three companies stated that generally all pre-certification requests can be done on the phone unless additional information is required for the decision. One company reported that all pre-certification is done by faxing a referral request form and including medical information. One company did not answer this question.

The answer to this question was not documented in the QA plan for the company that did not return the study questions. One company allows the PCP to determine medical necessity for all procedures except cosmetic conditions and transplants, which require medical record review; this information was found in the QA plan.

Comments: This type of information is not required to be in the QA plan.

f. How is PCP bonus or withhold affected when a patient exercises his POS option vs. when the referral is to an in-network provider?

Six companies reported that PCP bonus or withhold is not affected when a patient exercises his POS option. One company did not answer this question, and no standards were found in the QA plan. The answer to this question was not documented in the QA plan for the company that did not return the study questions.

One company mentioned in their QA plan that there is no withhold when a patient exercises the POS option, but there are penalties if the PCP refers a patient outside of the network.

Comments: This type of information is not required to be in the QA plan.

g. Does the HMO have standards for response time to providers requesting pre-authorization for services? Is there a plan for improved response times?

One company did not indicate a specific response time, but did state that determinations were made at the time of receipt of all medically necessary information. They do have a process for monitoring timeliness of response. Three companies reported that pre-authorizations are normally provided within 24 hours of receipt of all necessary information, and they all have a process for monitoring timeliness. One company stated that their standard response time is between 24 and 48 hours when all information is available. This response time increases to between 7 and 10 days when more information is required. This plan conducted a study of their response time and found that they responded within 24 to 48 hours 95% of the time. One company processes routine care requests within 2 business days, and urgent care requests within 1 business day; they have an electronic tracking system to analyze timeliness of response. No documentation was found in these six QA plans. One company did not answer this question, and no standards were found in the QA plan. The answer to this question was not documented in the QA plan for the company that did not return the study questions. One company makes decisions within 2 business days; this information was found in the QA plan.

Comments: Only one company has this information available in detail in their QA plan.

h. Are physicians at risk for more than services provided in their offices through use of either of the following reimbursement methods?

Global Capitation: "a type of reimbursement in which an entity such as a physician-hospital organization is reimbursed a capitation amount for a particular group of members, and such entity is responsible for providing or paying for all (or most) of the covered services provided to those members by any provider."

> Episode of Care reimbursement: "A provider is paid a fixed dollar amount for the treatment of a specific illness, condition, surgery or episode of care. The provider is responsible for using this fixed payment to cover all expenses related to such illness, condition, surgery or episode of care. For example, a surgical group would be responsible for using this fee to cover the hip joint surgery and related expenses such as anesthesia, radiology, hospitalization, etc."

Four companies do not use either of these methods. The answer to this question was not documented in the QA plan for the company that did not return the study questions. One company uses per diem rates in contracts with hospitals, skilled nursing facilities, subacute units, and ambulatory surgery centers. One company uses capitation for all offices services provided by its PCPs, a combination of capitation and fee-for-service for its specialists, and per diems for hospital care; in addition, certain ancillary providers are paid using fee schedules. Two companies did not respond, and this information could not be found in the QA plan.

i. What specialties are paid by capitation?

One company capitates laboratory and radiology services. Three companies do not capitate any services. The answer to this question was not documented in the QA plan for the company that did not return the study questions. One company capitates GI, physical therapy, laboratory, and radiology. One company reported that they capitate most specialty support services such as radiology, podiatry, and outpatient mental health services. Two companies did not respond, and no documentation could be found in their QA plans.

Comments: This type of information is not required to be in the QA plan.

4. Credentialing

a. What credentialing activities are identified in the plan?

All nine companies presented detailed guidelines for credentialing in their QA plans that comply with NCQA standards. Two companies specifically mention using NCQA standards. Recredentialing is conducted every two years, except one company reviews providers annually during their first two years of participation. One company's answer to the study question was much more extensive than the information presented in the QA plan. Information could not be verified for the company that did not provide their QA plan.

b. What credentialing activities are done in the interim between recredentialing?

Eight companies report that they continue to monitor their providers in terms of licenses, DEA certificates, and malpractice insurance. Also, in one company, if any adverse information is reported about any of their providers, a special review is conducted; guidelines for this special review are in the QA plan. Six of these companies also perform ongoing medical

record review and quality indicators reviews. Five of these companies described these activities in their QA plans, but information could not be verified for the company that did not provide their QA plan.

One company reviews provider files as needed; this information was outlined in the QA plan.

c. How is the HMO informed of providers whose licenses are revoked or suspended?

One company uses the National Practitioner Data Bank and utilizes reports from licensing boards and HCFA; this information was not found in the QA plan. One company has contracted with an NCQA-certified agency that informs them when any of their providers have licenses revoked or suspended. The company verifies this information and follows-up as needed. One company queries the various states where they do business to check current licensing; currently Virginia publishes this information every two years. One company receives the information directly from the State Board of Medical Examiners, but does not indicate how often that information is obtained. Two companies stated they verify all information at the time of credentialing. One company sends a service coordinator to each provider's office quarterly; they rely on the provider to inform them of licensing problems between formal credentialing periods. One company requires their providers to inform them of any actions against their license; this company also utilizes other national and state-level sources. The answer to this question was not documented in the QA plan for the company that did not return the study questions.

Comments: Only one company has a system for prompt notification of license suspension or revocation. A provider could continue to practice for over a year before some plans learn of their license status. However, credentialing is an important part of all nine company QA plans.

5. Consumer Satisfaction

a. What activities does the plan describe to assess consumer satisfaction?

One company has been doing consumer surveys for ten years, using the GHAA survey until 1996, when they started using NCQA's HEDIS member satisfaction survey. This company also does routine group-specific surveys and disenrollment surveys. Focus groups with members and providers are being established. All of this information was mentioned in a less detailed format in the QA plan.

Five companies perform several annual surveys, including a member satisfaction survey and a disenrollment survey. This information was outlined without much detail in the QA plan for four of these companies, and could not be verified for the company that did not submit their QA plan. One company utilizes the Gallup organization for annual surveys. One company incorporates 60% of the NCQA survey's questions for their annual survey. Five companies use the entire HEDIS member satisfaction survey. One company did not answer this question, but their QA plan describes ongoing surveys to assess consumer satisfaction.

Comments: Measurement of customer satisfaction, an NCQA requirement, happens in all plans in one form or another. Standardization of satisfaction surveys will increase the utility of the results across plans.

b. If a survey is undertaken, what does the HMO do to ensure scientific validity and reliability of the instrument?

The five companies who currently use the HEDIS survey use HEDIS measurement guidelines. These companies outsource additional satisfaction surveys to a survey company. Two of these five companies also developed internal surveys that are reviewed annually by internal staff. One plan works with their outside vendor to ensure validity and reliability; this information is not detailed in the QA plan. One company sends out annual satisfaction surveys to a majority of their members, but this information could not be verified because they did not provide their QA plan. The answer to this question was not documented in the QA plan for the company that did not return the study questions or for the company that didn't answer the question.

c. What activities are identified by the plan that address UR denial and appeals?

Six companies routinely analyze their UR denial and appeals data for trends and address problems as they arise. Recent areas of member concern led to the initiation of review groups for one company. This information was not specifically mentioned in the QA plan, but provisions for periodic review of all plan data are outlined.

Two companies send information about how to appeal to all enrollees in their Certificate of Coverage, but did not mention if they specifically track UR denial and appeals. One company did not answer this question, but their QA plan shows routine collection of UR information.

Comments: This question might have been ambiguous. Most plans track UR denial and appeals, but it was not clear if they looked at this issue in terms of customer satisfaction with the appeals process.

d. How does the HMO comply with §38.2-4304.B? ("The governing body [of the HMO] shall establish a mechanism to provide the enrollees with an opportunity to participate in matters of policy and operation through (I) the establishment of advisory panels, (II) the use of advisory referenda on major policy decisions, or (III) the use of other mechanisms.")

Two companies have established a Member Advisory Committee. One company has established an enrollee focus group and solicits enrollee feedback at enrollment sites. One company does not have a formal advisory group, but does have consumer representation on their Board of Directors, uses focus groups, and solicits comments through mailed surveys. One

company has consumer membership on their governing board, focus groups, and consumer participation on their grievance committee. Another company uses both member surveys and Client Advisory Forums. One company solicits member feedback only through an annual satisfaction survey. One company did not answer this question, and the answer was not found in the QA plan. The answer to this question was not documented in the QA plan for the company that did not return the study questions.

Comments: Plans have complied with this regulation, but it is often unclear how enrollees are chosen to serve on advisory committees or what impact their views have on company policy.

e. Do members receive physician-specific performance information such as "report cards"?

Seven companies report that they do not send members physician-specific performance information. One company (NYL) did report that names of providers who receive awards for excellence are named in the member newsletter, and one company noted that they do not send this information to members because they don't want this information used in a punitive manner.

One company provides report cards on primary care offices to their members upon request. The answer to this question was not documented in the QA plan for the plan that did not return the study questions.

Comments: Physician-level data are not often released from any insurance plan because it is difficult to adjust for all risk factors that might affect the way a particular provider practices. For example, Virginia Health Information is currently working on a study that will provide physician-specific data for obstetricians in the Commonwealth; many parties are concerned that some providers will be unfairly represented by these data.

f. Are physician satisfaction surveys undertaken? If so, how are they conducted? What is done with the results?

One company stated that they conduct provider satisfaction surveys every six months by mail. The results of the surveys are kept internally to help identify problems. One company conducted a single telephone survey of randomly selected providers; these data were kept internally for strategic planning purposes. One company contracts with an outside vendor to perform the survey every 1 to 2 years using internally developed instruments; results are used to help improve services. One company conducts an annual provider satisfaction survey and quarterly PCP turnover rate reviews; the information is used internally to improve performance. Three companies conduct annual surveys that are also used internally. One company has not conducted any provider surveys. One company reported doing patient satisfaction surveys that focus on patient satisfaction with their providers, but it was noted in their QA plan that they also conducted provider surveys. All but one company mentioned doing provider satisfaction surveys

in their QA plan.

Comments: Only one plan reported not doing any provider satisfaction surveys.

g. Does the provider relations department track provider complaints and concerns? How?

Four companies have a provider relations department that tracks provider complaints and concerns through an automated system. One company utilizes their regular customer service department but flags provider complaints for later analysis. This was not documented in the QA plans. One company uses the customer log system described in their grievance procedures, but they did not elaborate how they separate provider complaints from enrollee complaints. One company is currently initiating a special online tracking system for all provider calls. The answer to this question was not documented in the QA plan for the company that did not return the study questions and for the company that did not respond to this question.

6. Improvement of Community Health

a. What focused studies are identified in the goals and objectives of the plan (i.e., disease-specific, population specific)? Are methodologies identified?

Five companies mentioned several focused studies that were both disease-specific (diabetes) and population-specific (Medicare). These studies and methodologies are outlined in the QA work plan for three companies, one company reported that methodologies were not in their QA plan, and information could not be verified for the company that did not submit their QA plan.

One company reported that they are revising all of their focused study programs in order to meet NCQA standards, so they could not provide details. One company described their ambulatory medical record review as a way to measure quality of care standards, but did not mention any specific focused studies. One company did not answer this question, but their QA work plan describes multiple outcome studies. One company described utilization studies based on diagnosis, but methodologies were not found in the QA plan.

b. What provisions does the plan make for feedback to providers concerning QA activities in general and specific outcomes of care in particular?

One company contracts with an outside agency to perform continuous assessments and reports these assessments to their providers on a monthly and annual basis, but this information could not be verified because they did not provide their QA plan. One company uses their physician relations department to disseminate this information through a printed and online newsletter. Feedback is encouraged through both media.

Four companies distribute a newsletter, send direct letters to providers, and present educational programs. Two of these companies had these procedures set out in detail in the QA work plan, while the other two companies mentioned these activities without detail.

One company did not outline their provisions in their QA plan, but stated that they send letters with specific concerns to the involved provider, distribute a newsletter to all providers, and send out periodic mailings on specific topics. One company did not respond to this question, but an examination of their QA plan showed that communicating the results to practitioners and members is one of the objectives of the quality improvement process. The answer to this question could not be determined for the company that did not provide survey answers, but the QA plan does mention quality monitoring and feedback to regional offices.

7. Outcome Measures

What activities does the plan indicate will be initiated to address poor clinical outcomes such as death, readmission to the hospital, hospitalization following ambulatory surgery, unscheduled return to the O.R., post-op infections?

Eight companies track poor clinical outcomes (readmissions to hospitals, emergency room visits after physician office visits, outcomes after adverse decisions, mortality) and analyze these data on a regular basis. Action is taken on all quality concerns, including conferencing with providers. Two companies have also undertaken focused studies on certain adverse clinical outcomes, such as readmissions.

This process is outlined in the QA work plan of five of the eight companies. One company did not respond to this question, but an examination of their QA plan revealed specific plans to address unplanned readmissions after adverse decisions and admissions after ambulatory surgery. One company had a very detailed answer to the study question, but had no documentation in their QA plan. One company did not have any of this information in their QA plan. Information could not be verified for the company that did not provide their QA plan.

The answer to this question was not documented in the QA plan for the company that did not return the study questions, but they did report overall tracking measures.

Conclusions: The QA plans for the companies that responded to our requests were fairly complete and relatively easy to read, but what constitutes a QA plan in one company does not always correspond to the QA plan of another company. For instance, one company sent a QA plan that was approximately 1000 pages in length that included all internal and external QA policies. In contrast, one company had a QA plan that was 14 pages in length. There were many instances where detail, such as the target times for patient appointments, was not documented. Also, grievance procedures were often separate from the QA plan, not included as a part of the overall plan. We did not visit any of these sites, nor did we look at all the materials that an organization such as NCQA would during an accreditation visit. We could only analyze the information that was provided to us by these companies, which might not have always been complete.